

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  155171	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED  06/19/2013
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NAME OF PROVIDER OR SUPPLIER  FRANKLIN MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1285 W JEFFERSON ST FRANKLIN, IN 46131
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F000000	<p>This visit was for a Recertification and State Licensure Survey.</p> <p>This visit was in conjunction to the investigation of Complaint IN00130273.</p> <p>Survey dates: June 11, 12, 13, 14, 17, 18, and 19, 2013</p> <p>Facility Number: 000087 Provider Number: 155171 AIM Number: 100289890</p> <p>Survey team: Dinah Jones, RN-TC Marcy Smith, RN Leia Alley, RN</p> <p>Census bed type: SNF/NF: 89 Total: 89</p> <p>Census payor type: Medicaid: 73 Medicare: 2 Other: 14 Total: 89</p> <p>These deficiencies reflect state findings cited in accordance with 410 IAC 16.2.</p>	F000000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Quality review completed on June 25, 2013; by Kimberly Perigo, RN.				

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F000226 SS=C	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>Based on interview and record review, the facility failed to develop an an abuse prohibition policy which clearly and specifically reflected the requirements to report incidences immediately to the required authorities, physicians, and resident representatives. This had the potential to affect 89 of 89 residents residing in the facility.</p> <p>Findings include:</p> <p>A review of the facility policy on 6/17/13 at 10:00 a.m., entitled, "Abuse Prohibition, Reporting and Investigation Policy and Procedure" written, February 2010 and revised September 2012, indicated on page #3, "the Executive Director/designee will report all unusual occurrences..." to the Long Term Care Division of the Indiana State Department of Health within 24 hours". The policy did not indicate the definition of "unusual occurrences." The time frame of 24 hours did not indicate immediacy.</p>	F000226	<p>There were no residents sited in this deficient practice. Abuse prohibition policy reflects the requirement to report incidents immediately to require authorities, physician and resident representatives</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>There were no residents sited in this deficient practice. Abuse prohibition policy reflects the requirement to report incidents immediately to require authorities, physician and resident representatives</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b></p> <p>The abuse prohibition policy reflects the requirement to report incidents immediately to required authorities, physician and resident representatives.</p>	07/19/2013	

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	<p>In an interview with the Executive Director on 6/18/13 at 3:30 p.m., he indicated the use of "unusual occurrences" could be open to interpretation. He indicated, "what may be an unusual occurrence in one facility, may not be considered an unusual occurrence in another."</p> <p>On page 2, paragraph 5, the policy indicated the Executive Director was to be notified immediately of all abuse allegations and notification was to be made within 24 hours to the resident's representative. The time frame of 24 hours did not indicate the immediacy.</p> <p>3.1-28(a)</p>		<p>Staff members will be in-serviced on the definition of unusual occurrences and report incidents, and revised policy by July 19, 2013 by the SDC/Designee. ED/Designee will ensure all unusual occurrences are reported immediately to required authorities, by tracking and submitting a log to the DO monthly.</p> <p><b>What measures will be put into place or what systemic changes</b> Staff members will be in-serviced on the definition of unusual occurrences and report incidents, and revised policy by July 19, 2013. On July 16, 2013 ED/Designee will ensure all unusual occurrences are reported immediately to required authorities,</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> Will utilize CQI tool weekly x4 monthly x2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 100% is not achieved then an action plan will be developed to assure compliance. Ed with permission will attend resident council</p>		

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			<p>meeting to discuss abuse policy monthly x 3.</p> <p>ED/Designee will ensure all unusual occurrences are reported immediately to required authorities, by tracking and submitting a log to the DO monthly</p> <p><b>What is the date by which the systemic changes will be completed?</b></p> <p>July 19, 2013.</p>		

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F000241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>Based on observation and record review, the facility failed to maintain a resident's dignity while providing incontinence care. This affected 1 of 1 residents in a sample of 8 who met the criteria for review of urinary incontinence in a total sample of 35. (Resident #69.) (C.N.A. #1 and #2)</p> <p>Findings Include:</p> <p>The clinical record for Resident #69 was reviewed on on 6/12/13 at 11:00 a.m.</p> <p>Diagnoses for Resident #69 included, but were not limited to profound mental retardation and developmental delay, schizophrenia, and dementia.</p> <p>During an observation of incontinence care, on 6/12/13 at 9:15 a.m., Resident #69 was saying in a loud voice, "coke!" "coke!" and "no", "no, COKE!." CNA #1, (Certified Nurses Assistant), stated, "We can get you cleaned up and then you can have a coke with lunch," CNA #2 stated</p>	F000241	<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #69 continues to be provided personal care, dignity, well-being and proper delivery of care.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.</b></p> <p>All residents have the potential of being affected by the alleged deficient practice. Staff have been re-educated on enhancing each residents and respect and full recognition of his/her individuality by the SDC on June 28, 2013. <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Staff will be re-educated on enhancing each residents and respect and full recognition of his/her individuality. Inservices will be held by SDC-designee and completed by July 16, 2013. Manager on duty will ensure dignity and respect through daily</p>	07/19/2013

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	<p>"you're nuts," toward the resident and then looked at CNA #1 and stated in a very low whisper, "she's going nuts." CNA #2 then stated, "she's showing off."</p> <p>A policy titled, "Resident Rights", dated 8/98, indicated, "All staff members recognize the rights of residents at all times and residents assume their responsibilities to enable personal dignity, well being, and proper delivery of care."</p> <p>3.1-3(t)</p>		<p>rounds. Compliance will be monitored by DNS/designee.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>The SDC provided the inservice on June 28, 2013. The Charge nurse/Manager on Duty /Designee will ensure dignity and respect through daily rounds will be conducted to monitor staff to resident interactions. <b>Dignity and privacy tool will be utilize</b></p> <p>Will utilize dignity CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance.</p> <p><b>What is the date by which the systemic changes will be completed?</b> July 19, 2013</p>		

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F000247 SS=D	<p>483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed.</p> <p>Based on record review and interview, the facility failed to provide notification to a resident that she was receiving a new roommate for 1 of 2 residents who met the criteria for review of admission, transfer, and discharge in a total sample of 35. (Resident #91)</p> <p>Findings include:</p> <p>During an interview on 6/12/13 at 11:45 p.m., Resident #91 indicated the facility did not notify her when she received a new roommate.</p> <p>The clinical record of Resident #91 was reviewed on 6/19/13 at 10:00 a.m.</p> <p>Resident #91 was admitted to the facility on 6/15/12.</p> <p>An annual Minimum Data Set assessment, dated 4/17/13, indicated Resident #91 was independent with her decision making.</p> <p>Review of social services notes</p>	F000247	<p>F247</p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #91 is advised of room changes and any new roommates by social service/designee prior to room change or roommate changes.</p> <p><b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b></p> <p>Residents with a roommate or room changes have the potential of to be affected by the alleged deficient practice. Social</p>	07/19/2013			

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	<p>indicated the following:</p> <p>1/21/13: "no concerns with new roommate." 2/28/13: " no concerns with new roommate."</p> <p>No documentation was found in Resident #91's record, which indicated she was informed she was receiving a new roommate prior to 1/21/13 or 2/28/13.</p> <p>Further information was requested from the Social Service Director on 6/19/13 at 11:00 a.m., regarding whether Resident #91 was informed she was receiving a new roommate prior to 1/21/13 or 2/28/13.</p> <p>On 6/19/13 at 11:09 a.m., the Social Service Director indicated she was not able to find any information, which indicated Resident #91 was notified she was receiving a new roommate prior to the above dates.</p> <p>An undated facility policy, titled "[name of facility] Intra-Facility Transfers, received from the Administrator on 6/19/13 at 12:00 p.m., indicated, "6. The receiving roommate and/or legal representative will be notified of the new roommate prior to the move. This notification</p>		<p>Services were reeducated by Social Service consultant on notification and documentation of roommate or room changes on 6/26/13.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>IDT team will utilize Social Service CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance.</p> <p><b>What is the date by which the systemic changes will be completed?</b></p> <p>Completed on 6/26/13</p>				

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	will be documented in the medical record."  3.1-3(v)(2)				

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F000279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>Based on record review and interview, the facility failed to develop comprehensive care plans to meet the residents' medical needs for abdominal pain and diabetes mellitus, for 2 of 35 residents reviewed for care plans. (#32,#128)</p> <p>Findings include:</p> <p>1). The clinical record for resident #32 was reviewed on 6/18/13 at 3:04 p.m.</p> <p>Diagnoses included but were not</p>	F000279	<p><b>F279 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken</b> All residents have the potential to be affected by the alleged practice IDT nurse consultant/designee by July 19, 2013 on ensuring care plan reflects current medical condition and status <b>What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur</b> Review of care plans was conducted by DNS/Designee</p>	07/19/2013	

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	<p>limited to; anemia, heart failure, hypertension, depressive disorder, hemorrhoids without complication, hypopotassemia, esophageal reflux, chronic airway, congestive heart failure, chronic pain, and osteoarthritis.</p> <p>On 6/19/13 at 9:30 a.m., a clinical record review indicated physician's order for pain medication which included, but was not limited to; lidoderm 5% 700 mg [milligram] topical patch to be applied to the resident's lower back. The indication for use was, pain. The patch was to be applied twice daily.</p> <p>The physician also prescribed, percocet 5-325 mg 1 po [oral] q [every] 4 hours p.r.n. [as needed] and percocet 5-325 mg 1 po q.i.d. [four times per day] as a scheduled medication for the relief of back pain.</p> <p>During an interview on 6/19/13 at 9:45 a.m., an LPN [Licensed Practical Nurse] #3, indicated the resident had a long history of abdominal pain before admitting to the facility. He indicated as long as the resident received her scheduled pain medication, she did not complain of break through pain. The LPN indicated the resident rarely requested a p.r.n. dose of medication.</p>		<p>to ensure residents receiving pain medication and residents with diagnosis of diabetes have a care plan to address these medical needs. A care plan checklist has been developed to ensure diabetes and pain is care planned for all residents. This check list will be utilized by DNS/Designee to ensure a care plan addresses these medical needs. <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Will utilize care plan CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance.</p> <p><b>Compliance Date</b> July 19, 2013</p>		

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	<p>He indicated he was not aware of a specific care plan for the resident's abdominal pain.</p> <p>The resident had been referred by her physician, to a pain clinic and was going out of the facility for scheduled appointments for evaluations and treatments.</p> <p>A review of the resident's comprehensive care plans on 6/19/13 at 9:55 a.m., indicated a comprehensive care plan had not been initiated for the resident's known abdominal pain.</p> <p>2) The clinical record for Resident #128 was reviewed on 6/14/13 at 11:00 a.m</p> <p>A MDS (Minimum Data Set) assessment dated 3/22/13 indicated Resident #128 had a diagnosis of diabetes mellitus.</p> <p>A physicians order record dated June 2013, indicated Resident #128 was to receive "accu checks (blood sugar checks) QID [four times a day]."</p> <p>The clinical record lacked</p>						

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	<p>documentation in regard to a care plan for diabetes mellitus.</p> <p>Further information was requested from the facility Nurse Consultant on 6/14/13 at 12:00 p.m., in regard to a care plan for diabetes.</p> <p>During an interview with the facility Nurse Consultant on 6/14/13 at 3:00 p.m., she indicated no care plan was available.</p> <p>3.1-35(a)</p>				

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F000282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>Based on observation, record review and interview, the facility failed to ensure blood pressures were taken or reported to the physician, a feeding tube was checked for placement, and a medication was given as ordered, for 3 of 10 residents reviewed for medications being given according to the residents' plans of care in a total sample of 35. (Residents #77 and #73 and #49) (LPN#1)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #77 was reviewed on 6/14/13 at 9:50 a.m.</p> <p>Diagnoses for Resident #77 included, but were not limited to high blood pressure.</p> <p>A care plan for Resident #77, dated 12/1/11 and updated 6/1/13, indicated a problem of "Risk of ineffective tissue perfusion related to hypertension [high blood pressure]." The goal was, "Resident will maintain adequate tissue perfusion as evidenced by blood pressure within</p>	F000282	<p><b>F282 Qualified Persons</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #77 monitoring weekly per physician order for blood pressure and #73 medication regimes was adjusted per physician order with blood pressure monitor weekly.</p> <p>Resident #49 receives medication per physician orders and G-tube is checked for patency and gastric content. MD notified as needed.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient?</b></p>	07/19/2013			

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	<p>normal limits for resident..." An Approach was, "Observe for and document...variations in B/P [blood pressure]."</p> <p>Recapitulated physician orders for June, 2013, indicated Resident #77 was to receive Metoprolol, 50 mg, . (milligrams) once a day (original order date 4/13/12), lisinopril, 20 mg., once a day (original order date 3/9/12), and Norvasc, 2.5 mg., once a day (original order date 5/4/13). Metoprolol, lisinopril and Norvasc are medications given to treat high blood pressure.</p> <p>Review of Medication Administration Records for May, 2013, indicated Resident #77 received these medications as ordered.</p> <p>A recapitulated physician's order for June, 2013, with an original date of 3/28/11, indicated Resident #77 was to have her blood pressure checked every week.</p> <p>Review of a Vital Sign Report, dated from 3/1/13 to 6/14/13, received from the Medical Records staff on 6/17/13 at 9:00 a.m., indicated Resident #77's blood pressure was only checked on May 11 and May 25, 2013.</p> <p>Further information was requested</p>		<p>All residents have the potential to be affected by the alleged deficient practice. DNS/Designee will conduct rounds daily on all shifts to ensure appropriate place and G-tube procedures are followed. DNS/Designee will audit charts to ensure blood pressures are taken and reported per physician order. Licensed nurses have re-educated concerning placement and residual on documentation by SDC/Designee by July 19, 2013.</p> <p><b>What measures will be put into place or what systemic changes</b></p> <p>License nurses have been re-educated concerning placement and residual on documentation by SDC/designee by July 19, 2013. Upon hire licensed Nurses will perform skills validation concerning G-Tube procedures to assure competency. SDC/designee will complete a skills validation 3x a week x 2 weeks then 1 x a week x 4 weeks.</p>				

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	<p>from the Nurse Consultant on 6/14/13 at 9:30 a.m., regarding whether Resident #77's blood pressure had been checked any other time during May, 2013.</p> <p>On 6/14/13 at 11:22 a.m., the Nurse Consultant provided the same Vital Sign Report for May, 2013, and indicated at that time she was not able to find any other blood pressures done on Resident #77 during the month of May, 2013.</p> <p>2. The record of Resident #73 was reviewed on 6/18/13 at 9:10 a.m.</p> <p>Recapitulated physician's orders for June 2013, with original dates of 1/29/10, indicated Resident #73 was to receive hydrochlorothiazide 12.5 mg. every day, and metoprolol 50 mg. every day. Hydrochlorothiazide and Metoprolol are medications given to treat high blood pressure.</p> <p>Review of Medication Administration Records for April and May, 2013, indicated Resident #73 received hydrochlorothiazide and Metoprolol every day, as ordered.</p> <p>A recapitulated physician's order for June, 2013, with an original date of 10/24/12, indicated Resident</p>		<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Will utilize G-Tube CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance. ED with permission will attend resident council meeting to discuss abuse policy monthly x 3. SDC- designees will inservice staff.</p> <p><b>What is the date by which the systemic changes will be completed?</b></p> <p>July 19, 2013.</p>		

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	<p>#73's blood pressure was to be checked weekly and the physician should be notified if the systolic pressure was greater than 140 or the diastolic pressure was less than 80. The systolic pressure is the pressure of the blood against the walls of the blood vessels when the heart is contracting. The diastolic pressure is the pressure of the blood against the walls of the blood vessels when the heart is relaxed.</p> <p>Medication Administration Records for April, May, and June 2013, indicated Resident #73's blood pressure had been checked weekly as ordered. The records indicated all the diastolic pressures were less than 80. There was no documentation in the resident's record which indicated the physician had been notified.</p> <p>Further information was requested from the Nurse Consultant on 6/18/13 at 9:40 a.m. regarding whether the physician had been notified of Resident #73's diastolic pressures being less than 80. On 6/18/13 at 10:50 a.m., the nurse consultant indicated the physician had not been notified and they currently had a call in to his office.</p> <p>3) During an observation of</p>						

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	<p>medication administration for Resident #49 on 6/14/13 at 11:30 a.m., LPN #1 was noted to prepare a hydrocodone acetaminophen, 5-325mg tablet, by crushing the tablet and placing it in a medication cup.</p> <p>LPN #1 was then observed to add approximately 20 milliliters of water to the medication cup and administer the medication via Resident #49's gastric tube (tube placed in the stomach). LPN #1 did not check for placement of the gastric tube before she administered any medication. LPN #1 failed to empty the entire contents of the medication into the gastric tube. The medication cup had crushed, wet medication stuck to the bottom of it, and LPN #1 threw the cup away without trying to get the remaining medication out.</p> <p>Resident #49's clinical records were reviewed on 6/18/13 at 11:00 a.m.</p> <p>A physicians order dated 1/28/10 indicated, "Check residual (gastric contents in the stomach) every shift, notify MD (medical doctor) if greater than 60 mls(milliliters)."</p> <p>A physicians order dated 4/4/10 indicated, "verify patency (tube open/unclogged) and placement</p>				

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	<p>every shift."</p> <p>During an interview with the facility Nurse Consultant on 6/18/13 at 1:45 p.m., further information was requested in regard to what time LPN #1 had checked the placement of the gastric tube, and the Nurse Consultant indicated she would be unable to provide the time of the placement check.</p> <p>A facility policy titled, "Enteral Tube-Medication Administration", dated 01/2010, indicated, "dissolve each crushed medication..." and "check enteral tube for patency and gastric content."</p> <p>3.1-35(g)(2)</p>				

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F000315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>Based on observation and record review, the facility failed to provide proper incontinence care to prevent urinary tract infection or skin irritation for 1 of 1 residents reviewed in a sample of 8 who met the criteria for review of urinary incontinence, in a total sample of 35. (Resident #69) (C.N.A. #1 and #2)</p> <p>Findings Include:</p> <p>An observation of urinary incontinence care was made on 6/12/13 at 9:15 a.m. CNA #1 (Certified Nurses Assistant) and CNA #2 gathered necessary equipment, and started to provide care. CNA #1 donned gloves, assisted Resident #69 to stand, remove her pants and wet brief, and lie back on the residents bed. CNA #1 assisted Resident #69 to move her</p>	F000315	<p><b>F315 UTI/Catheters What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Resident #69 is receiving proper peri care with each episode. <b>How will you identify other residents having the potential to be affected by the same deficient?</b> Those residents who require assistance with incontinent care have the risk of being affected by alleged deficiency. Incontinent skills validation was completed on all CNSs by SDC on July 2, 2013. <b>What measures will be put into Designee to ensure appropriate incontinent care is provided</b> CNSs will be educated on proper peri care by July 16, 2013 by SDC/Designee. DNS/Designee will conduct rounds on each shift daily to ensure appropriate incontinent care is provided.</p>	07/19/2013			

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	<p>legs apart and proceeded with care.</p> <p>CNA #1 took a damp cloth, applied soap and wiped the leg crease of Resident #69's right leg and labia area, she folded the cloth and did the same step with the left leg crease and labia area. She then folded the cloth again and wiped the urethral area from top to bottom. CNA #1 was not noted to clean the buttocks area.</p> <p>The clinical record for Resident #69 was reviewed on on 6/12/13 at 11:00 a.m.</p> <p>Diagnoses for Resident #69 included, but were not limited to profound mental retardation and developmental delay, schizophrenia, and dementia.</p> <p>An annual MDS (Minimum Data Set) assessment was done on 5/7/13. The MDS indicated Resident #69 was always incontinent of bladder and required total assistance for personal hygiene needs.</p> <p>A facility policy titled, Perineal Care, dated 02/2010, indicated, " Separate labia and wash urethral area first."</p> <p>3.1-41(a)(2)</p>		<p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b> Will utilize skills validation for CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance. ED with permission will attend resident council meeting to discuss abuse policy monthly x 3. SDC- designees will inservice staff. <b>What is the date by which the systemic changes will be completed?</b> July 19, 2013.</p>		

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F000323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation and interview, the facility failed to ensure hazardous substances were secured and unobtainable to residents who resided on the Memory Care Unit. This had the potential to affect 15 of 15 residents. (Residents #96, #92, #106, #37, #55, # 90, #71, #15, #115, #28, #84, #120, #73, and #47)</p> <p>During a tour of the Memory Care Unit, a secured unit, on 6/11/13 at 11:00 a.m., the following was observed inside of an unlocked laundry room in the main hallway of the unit:</p> <p>1. The cabinet over the sink contained:</p> <p>a. 1 gallon bottle of disinfectant. The label on the bottle indicated, "Active ingredient ammonium chloride, germicidal detergent, hazardous to humans.</p> <p>b. Citrus spray and wipe 32 ounces. The label on the bottle read, "Causes eye irritation."</p> <p>c. Dishwashing liquid 60 ounces. The</p>	F000323	<p><b>F323 Accidents/Hazards supervision devices.</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Residents 96, 92, 106, 37, 55, 90, 71, 15, 115, 28, 84, 120, 73, 47. Lives in an environment free of accidents and hazards as possible. Laundry door fix 6/12/13 to ensure it is always locked.</p>	07/19/2013			

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	<p>label on the bottle read, "External use only. If swallowed, get medical help or contact poison control."</p> <p>2. The cabinet to the left of the dryer contained:</p> <p>a. One 4 ounce bottle of mouthwash. The label on the bottle read, "Do not swallow, do not use with patients suffering from cystic fibrosis."</p> <p>b. Six 4 ounce bottles of mouthwash. The label on the bottles read, "In case of accidental ingestion seek medical attention."</p> <p>c. Three 8.5 ounce bottles of shampoo/body wash. The label on the bottles read, "For external use only."</p> <p>d. Five 4 ounce bottles of liquid to "help prevent diaper rash dry cracked skin." The label on the bottles read, "If swallowed, get medical help or call poison control."</p> <p>3. On the floor, to the right of the door, a mop and an uncovered bucket half full of liquid was observed. During an interview with the Housekeeping Supervisor on 6/18/13 at 12:00 p.m., she indicated the liquid in the bucket kept in the laundry room in the Memory Care Unit was a floor cleaner. The label on the floor cleaner read, "Causes eye and skin irritation. Avoid contact with skin,</p>		<p><b>How will you identify other residents having the potential to be affected by the same deficient?</b></p> <p>All residents on memory care unit have the risk of being affected by alleged deficiency. Inservice conducted by Memory Care facilitator on June 26, 2013. Regarding keeping chemicals/hazards locked.</p> <p><b>What measures will be put into place or what systemic changes</b></p> <p>Staff has been re-educated by</p>		

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	<p>eyes, and clothing."</p> <p>4. On the floor to the right of the door, on a lower shelf, an unlocked tool box was observed. Items in the tool box included a hammer, pliers, and a screw driver.</p> <p>On 6/12/13 at 9:37 a.m., the laundry room door was again observed to be unlocked. During an interview with the Memory Care Program Facilitator at that time, he indicated the laundry room door should always be locked. He indicated there were items stored in the laundry room which could be hazardous to residents. He indicated he would call the Maintenance Director right away.</p> <p>During an interview with the Memory Care Program Facilitator on 6/19/13 at 10:45 a.m., he indicated all residents on this secured unit are able to propel themselves throughout the unit, either by walking or a wheelchair.</p> <p>3.1-45(a)(1)</p>		<p>Memory Care Facilitator on proper storage and hazards on June 28, 2013. Environmental rounds will be conducted daily by staff to ensure compliance. Maintenance man/designee daily on each shift laundry room is operational to ensure the laundry room door remains locked.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Will utilize environmental CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance</p> <p><b>What is the date by which the systemic changes will be</b></p>		

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			<p><b>completed?</b></p> <p><b>July 19, 2013.</b></p>	

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F000329 SS=D	<p><b>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</b></p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>Based on observation, record review, and interview, the facility failed to ensure blood pressures were taken or reported to the physician, for 2 of 10 residents who met the criteria for review of unnecessary medications in a total sample of 35. (Residents #77 and #73)</p> <p>Findings include:</p> <p>1. The clinical record of Resident #77 was reviewed on 6/14/13 at 9:50 a.m.</p>	F000329	<p><b>F329 Unnecessary drugs</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Resident #77 monitoring weekly per physician order for blood pressure and #73 medication</p>	07/19/2013	

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	<p>Diagnoses for Resident #77 included, but were not limited to high blood pressure.</p> <p>Recapitulated physician orders for June, 2013, indicated Resident #77 was to receive Metoprolol, 50 mg, . (milligrams) once a day (original order date 4/13/12), lisinopril, 20 mg., once a day (original order date 3/9/12), and Norvasc, 2.5 mg., once a day (original order date 5/4/13). Metoprolol, lisinopril and Norvasc are medications given to treat high blood pressure.</p> <p>Review of Medication Administration Records for May 2013, indicated Resident #77 received these medications as ordered.</p> <p>A recapitulated physician's order for June, 2013, with an original date of 3/28/11, indicated Resident #77 was to have her blood pressure checked every week.</p> <p>A care plan for Resident #77, dated 12/1/11 and updated 6/1/13, indicated a problem of "Risk of ineffective tissue perfusion related to hypertension [high blood pressure]." The goal was, "Resident will maintain adequate tissue perfusion as evidenced by blood pressure within</p>		<p>regimes was adjusted per physician order with blood pressure monitor weekly.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient?</b></p> <p>An audit of charts was conducted by DNS/Designee to ensure blood pressures were taken and reported per physician order. Inservice by SDC was conducted on June 26, 2013.</p> <p><b>What measures will be put into place or what systemic changes</b></p> <p>DNS/Designee will conduct</p>				

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	<p>normal limits for resident..." An Approach was, "Observe for and document...variations in B/P [blood pressure]."</p> <p>Review of a Vital Sign Report, dated 3/1/13 - 6/14/13, received from the Medical Records staff on 6/17/13 at 9:00 a.m., indicated Resident #77's blood pressure was only checked on May 11 and May 25, 2013.</p> <p>Further information was requested from the Nurse Consultant on 6/14/13 at 9:30 a.m., regarding whether Resident #77's blood pressure had been checked any other time during May, 2013.</p> <p>On 6/14/13 at 11:22 a.m., the Nurse Consultant provided the same Vital Sign Report for May, 2013, and indicated at that time she was not able to find any other blood pressures done on Resident #77 during the month of May, 2013.</p> <p>2. The record of Resident #73 was reviewed on 6/18/13 at 9:10 a.m.</p> <p>Recapitulated physician's orders for June, 2013, with original dates of 1/29/10, indicated Resident #73 was to receive hydrochlorothiazide 12.5 mg. every day, and metoprolol 50 mg.</p>		<p>rounds daily on all shifts to ensure physician orders are followed when blood pressures need to be monitored. DNS/Designee in serviced on June 26, 2013.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Will audit emar/tar Medication treatment CQI weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance.</p> <p><b>What is the date by which the systemic changes will be completed?</b></p>				

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	<p>every day. Hydrochlorothiazide and Metoprolol are medications given to treat high blood pressure.</p> <p>Review of Medication Administration Records for April and May, 2013, indicated Resident #73 received hydrochlorothiazide and Metoprolol every day, as ordered.</p> <p>A recapitulated physician's order for June, 2013, with an original date of 10/24/12, indicated Resident #73's blood pressure was to be checked weekly and the physician should be notified if the systolic pressure was greater than 140 or the diastolic pressure was less than 80. The systolic pressure is the pressure of the blood against the walls of the blood vessels when the heart is contracting. The diastolic pressure is the pressure of the blood against the walls of the blood vessels when the heart is relaxed.</p> <p>Medication Administration Records for April, May, and June 2013, indicated Resident #73's blood pressure had been checked weekly as ordered. The records indicated all the diastolic pressures were less than 80. There was no documentation in the resident's record, which indicated the physician had been notified.</p>		July 19, 2013.				

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	<p>Further information was requested from the Nurse Consultant on 6/18/13 at 9:40 a.m. regarding whether the physician had been notified of Resident #73's diastolic pressures being less than 80. On 6/18/13 at 10:50 a.m., the nurse consultant indicated the physician had not been notified and they currently had a call in to his office.</p> <p>3.1-48(a)(3)</p>			

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F000362 SS=C	<p><b>483.35(b)</b> <b>SUFFICIENT DIETARY SUPPORT PERSONNEL</b> The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.</p> <p>Based on observation, record review, and interview, the facility failed to ensure residents eating in the main dining room or in their rooms on D, A, and B halls, received their lunch meal within a reasonable time frame. This had the potential to affect 68 residents.</p> <p>Findings included:</p> <p>An undated meal schedule, received from the Administrator on 6/11/13 at 12:00 p.m., indicated lunch time for the residents eating in the Main Dining Room was 11:45 a.m. Lunch time for residents eating in their rooms on D, A, and B halls was 12:15.</p> <p>During an observation of lunch being served on 6/17/13 at 12:00 p.m., the following was observed:</p> <p>1. Meal service for those residents eating lunch in the Main Dining Room was not completed until 12:45 p.m.</p>	F000362	<p><b>F362 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Meals are served for residents on D, A and B halls within 15 minutes of the scheduled meal time. <b>How will you identify other residents having the potential to be affected by the same deficient?</b> All residents have the potential to be affected. Dietary staff was re-educated on July 2 nd 2013 by Certified Dietary Manager on procedures to ensure timely meal service. CDM/designee will monitor timely meal service each meal 7 days a week rotate days and meal to ensure each meal has been monitored for continued compliance.cdm <b>What measures will be put into place or what systemic changes</b> Dietary staff was in serviced on July 2 nd 2013 on procedures to ensure timely meal service by the certified dietary manager on July 2, 2013. Menus will be adjusted to accommodate difficult recipes by the registered dietician <b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur,</b></p>	07/19/2013	

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	<p>2. After the Main Dining Room residents were served, the kitchen staff began preparing lunch trays for residents eating in their rooms on D, A, and B halls. The last cart with the residents' meals going to D, A, and B halls did not leave the kitchen until 1:35 p.m.</p> <p>During in interview with the Dietary Manager on 6/17/13 at 1:40 p.m., she indicated, "This was a difficult meal to serve, there are so many steps to get the tacos ready to eat."</p> <p>On 6/18/13 at 10:36 a.m., the Dietary Manager provided an untitled document which indicated there were 45 residents who received their lunch meal in the Main Dining Room, and 23 residents who received lunch trays in their rooms on D, A, and B halls. She indicated, during an interview on 6/19/13 at 10:50 a.m., there were only 2 residents in the facility who did not receive meals from the facility kitchen.</p> <p>3.1-20(h)</p>		<p><b>i.e., what quality assurance program will be put into place</b> Will utilize Meal Monitoring CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance.</p> <p><b>What is the date by which the systemic changes will be completed? July 19, 2013.</b></p>		

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F000364 SS=E	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. Based on observation, record review, and interview, the facility failed to ensure a hot food being served from a steam table was maintained at 135 degrees or better. This had the potential to affect 7 of 87 residents who received their meals from the facility kitchen.</p> <p>Findings include:</p> <p>During an observation on 6/17/13 at 1:40 p.m., Cook #4 checked the temperatures of all the foods on the steam table after the last residents had received their meals.</p> <p>The temperature of the cheese sauce, which was put on the pureed taco meat, was 122 degrees. Cook #4 indicated, at that time, the temperature of the cheese sauce was not hot enough.</p> <p>On 6/18/13 at 10:36 a.m., the Dietary Manager provided an untitled document which indicated there were 7 residents in the facility who received a pureed diet.</p>	F000364	<p><b>F364</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>Hot food and cold food will be checked by serving staff prior to serving, and periodically throughout the meal to ensure appropriate temperature of food is served to the residents.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient?</b></p> <p>All residents have the potential to be affected by this alleged deficient practice.</p>	07/19/2013			

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	<p>A facility policy, dated 02/02, titled "Food Temperatures," received from the Dietary Manager on 6/18/13 at 10:36 a.m., indicated, "Policy The facility will prepare and serve food at the proper temperature to prevent food borne illness. Procedure 1. Hot foods that are potentially hazardous will leave the kitchen (or steam table) above 135 [degrees] F [Fahrenheit] ..."</p> <p>3.1-21(a)(2)</p>		<p>Certified Dietary Manager in serviced kitchen staff on July 2 2013 to check temperatures prior to serving, and periodically throughout the meal to ensure appropriate temperature of food is served to residents.</p> <p><b>What measures will be put into place or what systemic changes</b></p> <p>Certified Dietary manager will in-service kitchen staff when to take temperatures of food during serving, and how to correct if food is not at appropriate temperatures by July 2 nd , 2013. Dietary staff will take temperatures of the food before and after serving for each meal, and corrective action will be taken a log will be kept of each meal. Certified dietary manage will also monitor food temperatures, and monitor the food temp logs.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p>		

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			<p>Will utilize CQI temp monitor tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance</p> <p><b>What is the date by which the systemic changes will be completed?</b></p> <p><b>July 19, 2013.</b></p>	

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F000371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions Based on observation, record review, and interview, the facility failed to ensure proper sanitation methods were used while preparing and serving food in the kitchen and hand sanitizer was not used as a means of ensuring clean hands during food service. This had the potential to affect 84 of 89 residents who received food from the kitchen. (dietary aide #5)</p> <p>Findings include:</p> <p>During an observation in the facility kitchen on 6/11/13 at 10:50 a.m., Dietary Aide #5 lifted the lid on a covered trash can with his bare right hand, threw a box into the trash, returned to a prep table, picked up a box of juice, opened it, turned it upside down over a juice pitcher to empty it into the pitcher, dropped the box into the pitcher, put his bare right hand into the pitcher to remove the box, touching sides of the pitcher with his hand, emptied the rest of the juice</p>	F000371	<p><b>F371 What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b> Employee #5 was provided re-education on hand washing and sanitation procedures on June 26, 2013 Dietary Manager. RD re-educate staff on infection control and sanitation on July 2, 2013. <b>How will you identify other residents having the potential to be affected by the same deficient?</b> Residents who consume food from the kitchen have to possibility to be affected by this alleged deficient proactive. An inservice on hand washing and sanitation equipment conducted by CDM on July 2, 2013. <b>What measures will be put into place or what systemic changes</b> Re-educating of staff on hand washing and sanitizing equipment conducted by CDM on July 2, 2013. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put</p>	07/19/2013			

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	<p>from the box into the pitcher, used a pen he pulled from his pocket to prepare a label which he applied to the juice pitcher, then lifted the trash can lid with his bare left hand, wiped his left hand on his pants, picked up the juice pitcher and placed it in the refrigerator. He then began placing lids on a 18 glasses already filled with juice. When the lids were placed, he pulled a rag out of his pants pocket and wiped the prep table. At 11:02 a.m., he washed his hands.</p> <p>At 11:05 a.m., Dietary Aide #5 took a clean dry cloth from a box, rinsed it with faucet water, cleaned the prep table and then the condiment table with the same rag.</p> <p>During an interview with the Dietary Manager on 6/12/13 at 3:30 p.m., she indicated Dietary Aide #5 should have taken a towel soaking in sanitizing solution from a bucket next to the tap water sink to clean the prep tables. She indicated Dietary Aide #5 was a new employee and "he probably just forgot." She indicated employees should always wash their hands after touching the lid of the trash can.</p> <p>During an interview with the Dietary Manager on 6/19/13, she indicated there were 84 residents who could</p>		<p>into place CDM/designee will monitor hand washing, kitchen equipment all meals 7 days a week. Will utilize sanitation CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance. <b>What is the date by which the systemic changes will be completed?</b> July 19, 2013.</p>				

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	<p>receive juice from the kitchen during their meals.</p> <p>During an interview with Dietary Aide #5 and the Dietary Manager on 6/18/13 at 10:30 a.m., Dietary Aide #5 indicated he carried a small bottle of hand sanitizer in his pocket. He indicated he used it sometimes when he was in the serving line preparing trays of food for residents. He indicated he did not know anything about using hand sanitizer while working in the kitchen. At that time the Dietary Manager told Dietary Aide #5 he should never even bring hand sanitizer into the kitchen, that it is not supposed to be used around the preparation and serving of food.</p> <p>A facility policy, dated 02/02, received from the Dietary Manager on 6/18/13 at 10:36 a.m., titled, "Cleaning Counter Tops," indicated "Counter space will be wiped and sanitized prior to and following food preparation and meal service times...Spills will be wiped, as needed using a clean cloth stored in sanitizer solution...2. To sanitize..wipe counter with sanitizing solution..."</p> <p>3.1-21(i)(3)</p>						

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F000441 SS=D	<p><b>483.65</b> <b>INFECTION CONTROL, PREVENT SPREAD, LINENS</b> The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>Based on observation and interview, the facility failed to maintain sanitary</p>	F000441	F441	07/19/2013			

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	<p>medical equipment, by failing to sanitize a glucometer after checking a resident's blood sugar levels. This had the potential to affect all residents on "B Hall" who receive blood sugar monitoring. (LPN #2) (Resident #79)</p> <p>Findings Include:</p> <p>During an observation on 6/18/13 at 11:15 a.m., of Resident #79's blood sugar check, LPN (Licensed Practical Nurse) #2 was observed to return to the medication cart and improperly cleanse the glucometer (machine to check blood sugar levels). LPN #2 took an alcohol prep pad, wiped the glucometer, and then returned the glucometer to a drawer in the medication cart..</p> <p>During an interview at that time, LPN #2 indicated the facility cleans the glucometer machines at night with bleach wipes and lets the bleach sanitize the machine for 45 minutes, and then during the shifts in which residents receive blood sugar monitoring, the facility uses alcohol wipes to cleans the glucometer machines.</p> <p>During an interview with the facility Nurse Consultant on 6/18/13 at 11:45</p>		<p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>LPN #2 no longer employed at this facility</p> <p>Resident #79 has his blood sugar checked utilizing sanitized glucometer.</p> <p>Residents utilizing accuchecks are at risk for deficiency of alleged practice. Inservice conducted by SDC/designee on June 26, 2013 on proper glucometer cleaning.</p> <p><b>How will you identify other residents having the potential to be affected by the same deficient?</b></p> <p><b>What measures will be put into place or what systemic changes</b></p>		

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	<p>a.m., she indicated it is not the policy to cleanse with bleach at night, but to completely sanitize with a sani cloth (special sanitizing cloth) every time a blood sugar level was checked, and never to use an alcohol wipe to clean the glucometers.</p> <p>A facility policy titled, Glucose Meter Cleaning and Testing, dated 07/2011, indicated, "Obtain single-use germicidal wipe, Super Sani Cloth. Wipe entire external surface of the blood glucose meter with wipe for 2 minutes and ensure meter stays wet for 2 minute time period."</p> <p>3.1-18(a)</p>		<p><b>At that time Nurse #2 was provided one to one education On proper cleaning technique.</b></p> <p>License nurses have been re-educated concerning sanitizing of the accucheck check by SDC/designee on July 2, 2013. All licensed nurses will have skills validation completed for glucometer cleaning on July 2, 2013. Upon hire licensed Nurses will perform skills validation concerning sanitizing accucheck with 100% competency</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Will utilize Glucomoter CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be</p>		

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			<p>developed to assure compliance</p> <p><b>What is the date by which the systemic changes will be completed?</b></p> <p><b>July 19, 2013.</b></p>	

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F000465 SS=E	<p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>Based on observation and interview, the facility failed to maintain a home like environment by storing medical equipment in the hallway. This had the potential to affect 33 residents, who resided on A-Hall, in a total sample of 89.</p> <p>Findings Include:</p> <p>During an observation of A- Hall on 6/12/13 at 12 p.m., many medical and some housekeeping items were noted in the hall way, outside of resident's rooms. Items included: two wheelchairs a cleaning cart a trash barrel a linen barrel for dirty or soiled linen two dyna map machines (a rolling pole with vital sign equipment on it) two stand-up lifts (a large machine used to help residents stand upright) two hoyer lifts (a large machine used to lift residents who are not able to move) a medication cart</p>	F000465	<p><b>F465</b></p> <p><b>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?</b></p> <p>There were no identified residents for this alleged deficiency.</p> <p>Facility in the process of remodeling to create areas for storage of some items in the hall. Staff will be educated to keep necessary work items on one side of hall to allow for easy access of residents.</p> <p><b>How will you identify other residents having the potential to be affected by the same</b></p>	07/19/2013	

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	<p>a treatment cart a wet floor sign</p> <p>During an observation of A- Hall on 6/13/13 at 8:50 a.m., many medical and some housekeeping items were noted in the hall way, outside of resident's rooms. Items included: a food cart to bring meals three wheelchairs an electric or motorized wheelchair a cleaning cart a trash barrel a linen barrel for dirty or soiled linen two dyna map machines one stand-up lift one hoyer lift a bed side table, including a food tray that had breakfast food on it a medication cart a treatment cart</p> <p>During an observation of A- Hall on 6/14/13 at 9:00 a.m., many medical and some housekeeping items were noted in the hall way, outside of residents' rooms. Items included.. cans of nutritional shakes, stacked 6 cases high 20 boxes of supplies to put away in stock room area a food cart to bring meals two wheelchairs</p>		<p><b>deficient?</b></p> <p>All residents who reside in the facility have the potential to be affected by the alleged deficient allegations.</p> <p><b>What measures will be put into place or what systemic changes</b></p> <p>Remodeling facility had begun and will be completed in March of 2014. Upon completion there will be designated areas for placement of some items used for care kept on halls.</p> <p><b>How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place</b></p> <p>Staff will be educated on proper storage practices by Maintenance Director/Designee July 9, 2013 for each hall. Departmental managers to monitor on daily for</p>				

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	<p>an electric or motorized wheelchair a trash barrel a linen barrel for dirty or soiled linen one dyna map machine one stand up lift one hoyer lift a medication cart a treatment cart</p> <p>During an interview on 6/12/13 at 1:30 p.m., the facility Administrator indicated that normally the lift machines were kept in the shower areas when not in use. He also indicated that the facility will undergo renovations soon that will enable the trash and linen barrels to be out of sight.</p> <p>3.1-19(f)(5)</p>		<p>compliance.</p> <p>Will utilize life safety CQI tool weekly x 4 monthly x 2 then quarterly until continued compliance is utilized for two consecutive quarters. Results of audits will be reviewed by the CQI committee overseen by the ED. If threshold of 95% is not achieved then an action plan will be developed to assure compliance</p> <p><b>What is the date by which the systemic changes will be completed?</b></p> <p><b>July 19, 2013.</b></p>		